PAVING THE WAY FOR PHYSICALLY FIT AND HEALTHY CHILDREN

APPENDICES

A REPORT BY

THE LOS ANGELES COUNTY
TASK FORCE ON CHILDREN AND YOUTH PHYSICAL FITNESS

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DRAFT FOR REVIEW ONLY

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RECOMMENDED READING

Bright Futures in Practice: Nutrition: http://www.brightfutures.org/

Bright Futures in Practice: Physical Activity: http://www.brightfutures.org/

Board Motion "Task Force Formation": http://www.co.la.ca.us/ Board of Supervisors, Meetings of the Board, Board Meeting Recording and Transactions, January 29, 2002, 6.0 Board of Supervisors (Committee of Whole) #3

Board Motion "Support of Senate Bill 1520": http://www.co.la.ca.us/ Board of Supervisors, Meetings of the Board, Board Meeting Recording and Transactions, April 16, 2002, 5.0 Board of Supervisors (Committee of Whole) #3

Centers for Disease Control and Prevention. Increasing physical activity: a report on recommendations of the Task Force on Community Prevention Services. MMWR 2001;50(No.RR-18)

Healthier US Initiative. Website: http://www.healthierus.gov.

Healthy People 2010: http://www.health.gov/healthypeople/document/

Physical Activity and Health, A Report of the Surgeon General: http://www.surgeongeneral.gov/sgoffice.htm Publications, Reports of the Surgeon General

The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity 2001: http://ww.surgeongeneral.gov/sgoffice.htm Publications, Calls to Action
United Sates Department of Agriculture - Centers for Nutrition Policy and Promotion Strategic Plan 2000-20005: http://www.usda.gov/cnpp/

1999-2000 Los Angeles County Health Survey, Department of Health Services, Public Health: http://www.lapublichealth.org Select Health Assessment Unit from "Visit One of Our Programs"

Appendix B-1

Individuals and Families Workgroup: Summary of Discussions

1. **Major issues and gaps in nutrition and physical activity within the context of Individuals and Families:**

   a. Knowledge about healthy eating and physical activity habits:
      i. Families do not know how to and/or do not have the resources to cook with fruits and vegetables
      ii. Families feel they do not have the time to cook healthy meals or to exercise regularly
      iii. Purchasing fast food is perceived as easier and cheaper
      iv. Sometimes parents within the same family have conflicting ideas of what constitutes healthy eating habits
      v. Parents do not realize the physical and mental health risks associated with childhood obesity, and thus do not view obesity as a problem
      vi. Physical activity is viewed as "exercise" and not enjoyable (Families do not realize that activities such as, dancing, walking children to school or pushing a stroller is physical activity)
      vii. Families do not have the skills to advocate for physical activity centers or nutrition education in their community, neighborhood, schools, etc.
      viii. Too much attention is focused on dieting and exercise vs. wellness and a healthy lifestyle

   b. Access to nutritional and physical activity resources:
      i. Many communities throughout L.A. County lack safe, affordable and accessible venues for physical activity, e.g. walking and biking paths, parks and youth recreation centers
      ii. Many communities throughout L.A. County lack access to fresh and affordable produce and nutrition education
      iii. First generation immigrants cannot always find the foods they ate in their countries of origin (As a result, they alter their eating habits and may over-consume inexpensive high caloric and low nutrient foods that were not available in their home country)
      iv. There is a lack of culturally and linguistically appropriate nutrition and physical activity programs
      v. Staff people in child and youth-serving organizations receive little or no training in nutrition and physical activity.

   c. Individual Influences:
      Individuals may encounter any of the following situations that impede engaging in healthy eating and physical activity:

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Individuals and Families Summary Continued:

i. Children and youth may lack friends, siblings or other family members with whom to engage in physical activity
ii. Feelings of incompetence when participating in physical activity due to embarrassment about their appearance or lack of coordination
iii. Issues with body image (e.g. beliefs that sweating is not feminine, being overweight makes exercise unacceptable)
iv. Unsuccessful or unpleasant experiences with physical activity (e.g. being made to run as a form of punishment in school, being picked last to participate on a team, sports are too competitive)
v. Health problems or physical discomfort or pain which make physical activity difficult
vi. Issues of mental health (e.g. eating disorders, depression, anxiety, gaining weight as a form of self protection from abuse or harassment)
vii. A preference for sedentary activities, such as watching T.V., playing computer games, or studying, rather than engaging in physical activity

d. External Influences
   i. Families may not encourage children to participate in physical activity or eat nutritious foods (e.g. activities are not allowed because they are considered dangerous, not feminine/masculine)
   ii. Families may not provide positive roles models by participating in physical activity or eating healthy
   iii. Peers may not be participating in physical activities or healthy eating
   iv. Extensive advertising of high caloric and low nutrients foods
   v. Families' distrust of established systems can be a barrier

e. Data Needs
   i. Lack of a centralized website for individuals and families to access Los Angeles County resources
   ii. Lack of evidenced based data on successful programs and strategies aimed at improving the eating and physical activity habits of individuals and families

2. Suggested Recommendations to the Board of Supervisors

a. Programs and Strategies
   i. Facilitate focus groups to learn about individuals' and families' attitudes regarding diagnosis of childhood obesity and interventions that are culturally relevant, sensitive and acceptable in their delivery
   ii. Children in foster care have greater medical and mental health needs, which might exacerbate their risk of obesity.

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Individuals and Families Summary Continued:

iii. Educate relative caregivers and foster parents about resources for nutrition and fitness.
iv. Utilize Public health Nurses, placed in DCFS field offices, as resources to assist the children's social workers with information and resources.
v. Identify and promote promising practices for nutrition and physical activity programs to facilitate adaptation of successful programs in other communities
vi. Offer more low-cost programs for families on healthy eating and exercise habits Programs should:
    - Be tailored to the literacy levels of participants and utilize visual or hands-on learning techniques when participants are illiterate
    - Educate about healthy portion sizes
    - Demonstrate healthy cooking so people learn how to prepare healthy meals
    - Be family-friendly and not criticize parents for current practices which may promote obesity
    - Include time-management components so families learn how to juggle healthy cooking and exercise with work and other responsibilities
    - Include early intervention using public health nurses or lay educators for high quality education and support to families and children
    - Promote the concept of a "grocery tour" which educates people about produce available in different seasons, cooking with produce and other healthy ingredients, and meal preparation on a limited budget
    - Present parents various options for their children (and themselves) to exercise on a daily basis (e.g. walking up stairs rather than take the elevator, walking to the store, etc.)
vii. Expand WIC or create new programs to provide vouchers to low-income families to purchase produce and other healthy foods
viii. Encourage food banks to provide adequate amounts of produce to low-income families
ix. Revive the "Passport Program" to promote free physical activity programs for families
x. Involve supermarkets in providing nutrition education
xi. Sponsor walking clubs at malls and other community locations such as schools or recreation centers/parks
xii. Expand parent education opportunities by providing nutritional and physical fitness education to Parent Teachers Association and Head Start and Healthy Start parent advisory groups
xiii. Promote programs and strategies that focus on the whole family
xiv. Develop linkages with the private sector (e.g. athletic apparel industry) to enlist businesses' support of community nutrition and physical fitness programs
xv. Pediatricians need to serve as a community resource for multiple services to prevent obesity

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Individuals and Families Summary Continued:

xvi. Create a mentor program where families, who are successfully raising fit and non-obese children, successfully volunteer to mentor families in which children are obese
xvii. Pediatricians and other health providers need to work with nutritionists for early intervention of obesity

a. Public Awareness and Education Opportunities

i. Develop a social marketing campaign for Los Angeles County to promote healthy eating and physical activity habits. Information messages need to:
- be age and gender specific as well as have messages targeting the whole family
- send consistent messages using national guidelines, such as the USDA's Food Guide Pyramid and Dietary Guidelines for Americans
- break down false barriers (e.g. individuals may say they do not have time to be physically active, but could utilize stairs instead of the elevator)
- include tools on how to accomplish physical fitness
- stress the impact and effect of obesity and that it has surpassed the effect of smoking, on one's health
- focus on increased physical activity and fruit and vegetable consumption
- educate on healthy portion sizes
- include famous athletes to promote physical activity
- be integrated into everyday life situations (e.g. point of decision marketing – provide recipes in the grocery store on how to cook with fruits and vegetables)
- incorporate messages that physical activity at any weight improves health (one does not have to be skinny and messages should not be about losing weight)

ii. Educate staff at preschool and after school programs, as well as child care providers and about healthy eating habits so they can promote healthy eating at their programs (including healthy food in their vending machines)
iii. Encourage television stations to offer programs on nutrition and healthy cooking, as well as physical activity
iv. Need to start a social movement concerning wellness of youth and families with the holistic approach

b. Policy/Advocacy Opportunities

i. Lobby for more funds to increase the number of community-based nutrition and physical fitness services for low-income families
ii. Lobby for more funds to support university programs to train professional nutrition and physical education instructors
iii. Recommend that the Department of Social Services, Community Care Licensing Division provide a unit or course on nutrition and physical fitness as a requirement for licensure of and employment of licensed child care providers

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Individuals and Families Summary Continued:

iv. Increase coverage by health insurance for exercise and nutrition programs
v. Lobby for obesity to be construed as a legal issue, i.e. that parents who let their children become obese are neglectful.
vi. Encourage community residents to advocate for more markets and farmers' markets in their neighborhood
vii. Promote standards of food quality county-wide so that all people, regardless of income and geography, have access to high quality produce and other healthy foods

c. Research Opportunities
   i. Promote research to determine effectiveness of programs that seek to improve the eating and physical activity habits of individuals and families
   ii. Research what "healthier" communities statewide and nationwide are doing to decrease childhood obesity so we can learn from them
   iii. Research the link between physical activity on a regular basis and performance in school.

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Community Workgroup: Summary of Discussions to Date

1. **Major issues and gaps in nutrition and physical activity within the context of Communities:**

   a. Lack of Knowledge
      i. Difficult to incorporate healthy eating and physical activity into daily routines
      ii. Physical fitness is not a personal or community priority (Survival and meeting basic needs come first. Understanding the benefits of adopting a healthy lifestyle does not necessarily transfer to behavior change.)
      iii. Physical activity is viewed as "exercise" and not enjoyable (Families may not realize that activities such as, dancing, walking, biking all "count" as physical activity)
      iv. Different communities have different perceptions about fast food. For example, in "the old country", people often could not afford fast food, so some immigrants may see this as a high-end choice.

   b. Access Problems
      i. Lack of Green Space/parks in Inner-city areas
      ii. Children have access to too many unhealthy choices
      iii. Children are not being introduced to healthy foods
      iv. Health disparities
      v. Lack of safe transportation to physical activity locations, grocery stores, and community based programs
      vi. Lack of advocacy for physical activity or nutrition in the community, neighborhood, schools, etc.)
      vii. Lack of safe environments for indoor and outdoor physical activity (e.g. walking and biking paths, playgrounds, parks and recreation centers)
      viii. Lack of affordable programs that promote physical activity and nutrition in children
      ix. Lack of grocery stores or places to purchase fresh and affordable produce.
      x. Fast food restaurants are more accessible and perceived as cheaper
      xi. Lack of space for play/exercise equipment and home gardening
      xii. Current park and exercise facilities are run down and need to be replaced
      xiii. Not all programs are culturally or linguistically appropriate

   c. Issues in the Schools
      i. Cuts in Physical Education Programs
      ii. Lack of nutritional value in school lunches (Children can choose the least healthy options)

Appendix B-2

Communities Continued:

iii. Vending and coke machines at parks and schools
iv. Minimal partnerships with the public and private sector to utilize recreational space

d. Data Needs
   i. Lack of a centralized website for community members to access Los Angeles County resources
   ii. Few successful evidence based community programs and strategies

e. Coordination of Effort
   i. Lack of coordination and partnerships with the public and private sectors
   ii. Lack of media campaign messages promoting good health and physical fitness (Too much attention is focused on dieting and exercise vs. wellness or a healthy lifestyle

2. Suggested Recommendations to the Board of Supervisors

a. Programs and Strategies
   i. Advocate for programs that change norms and behavior
   ii. Maximize and develop partnerships between the Department of Health Services, Department of Parks and Recreation and schools, communities, churches, hospitals and the city of Los Angeles to provide wellness programs and space for physical activity programs
   iii. Coordinate with police and sheriff departments to facilitate safe play and exercise opportunities such as community walks, utilizing community based policing
   iv. Expand community gardening sites utilizing County property with priority given to schools and community housing projects
   v. Encourage community specific programming (e.g. inner-city communities may need more indoor opportunities as there is lack of green space)
   vi. Advocate for workplace wellness programs to stress physical activity in the workplace during breaks and lunch time and offer incentives concerning good health (explore financial opportunities with employee health insurance programs as a result of wellness programs)
   vii. Promote and increase opportunities for non-competitive activities
   viii. Include private sector in building collaborations with the public and other agencies to increase nutrition and physical activity opportunities
   ix. Establish quarterly messages regarding nutrition and physical activity in County paychecks - support fitness breaks and include educational messages in newsletters, with pay warrants, etc
   x. Model publicly funded food programs after WIC by providing educational messages along with food stamps and meals on wheels.

Appendix B-2

Communities Continued:

xi. Encourage gardening in general, not just in low-income areas.
xii. Provide funding to groups that can serve as a community conduit, rather than funding the activity itself.
xiii. Facilitate rebuilding of communities
xiv. Give residents pedometers so that they can count the number of steps they walk every day and encourage businesses to give discounts to individuals who walk
xv. Empower community residents about how to advocate for what they need. For example, empower residents to take part in public hearings on where fast food businesses will be located.
xvi. Tap into existing resources, such as 1) the entertainment community 2) CBOs that are already providing services and 3) the census as an educational opportunity.
xvii. Initiate or beef up Healthy Cities campaigns throughout the County and make sure every city has a Plan of Action that addresses obesity and physical fitness.
xviii. Ensure Community designed health education strategies and programs (This was suggested as its own category and not under programs and services)
    1. Conduct needs assessments at the neighborhood level and get the data back into the hands of community members so that communities can develop their own recommendations for what will work in their area. The Partnership for the Public's Health project in the Montebello neighborhood of Lohart was given as an example).
    2. Conduct trainings at the community level that seek to empower residents in areas like leadership skills and community organizing.
    3. Utilize programs that help to develop and organize community members, like the promotora model.

b. Public Awareness and Education Opportunities "Public Awareness and Education Opportunities" should come before any other section.
    i. Develop public awareness/social marketing campaigns with specific focus on changing social norms. Information messages need to:
        - be age and gender specific as well as have messages targeting the whole family and communities
        - break down false barriers (e.g. individuals may say they do not have time to be physically active, but could utilize stairs instead of the elevator)
        - include tools on how to accomplish physical fitness
        - stress the impact and effect of obesity and that it has surpassed the effect of smoking, on one's health
        - focus on increased physical activity and fruit and vegetable consumption
        - be integrated into everyday life situations (e.g. point of decision marketing – taking the stair is better for your health than riding the elevator)

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Communities Continued:

ii. Need to start a social movement concerning wellness of youth and families with the holistic approach
iii. Educate and inform the media, and get their buy in (i.e. like Project REACH does)

c. Policy/Advocacy Opportunities
   i. Support SB19 on school nutrition
   ii. Support SB 1520 on Soda taxation
   iii. Investigate potential policy change at the city and county level
   iv. Mandate comprehensive workplace wellness programs in all County facilities
   v. Offer incentives for workplace wellness programs of County grantees
   vi. Promote physical activity stations and community gardens in Public Housing Projects
   vii. The Board of Supervisors should develop ongoing relationships with individuals that make policy on physical fitness, nutrition, and obesity issues and continue to take a stand on these issues in the future.

d. Research Opportunities
   i. Promote research to determine effectiveness of programs targeting improving nutrition and increasing physical activity in communities
   ii. Establish a centralized information source (website) to promote successful programs and resources
   iii. Direct appropriate funding opportunities for research and service delivery to stakeholders
   iv. Utilize the L.A. Health Survey to gather and map changes regarding children and youth physical fitness
   v. Ensure Info Line has adequate information about physical fitness, obesity, and nutrition programs; if not, increase the quality and quantity of information or start a new toll free line specifically on these issues.
   vi. Ensure data is disseminated in a timely fashion, so that research can be translated into action.

Appendix B-3

Schools Workgroup: Summary of Discussions

1. **Major issues and gaps in nutrition and physical activity within the context of Schools:**

   i. School Environment and Policies
      i. Lack of comprehensive school district policies related to Coordinated School Health Program (CSHP): Healthy and Safe School Environment; Health Education; Physical Education; Nutrition Services; Health Services; Counseling, Psychological and Social Services; Health Promotion for Staff; and Family and Community Involvement
      ii. Lack of school district Coordinated School Health Teams to implement and oversee school health programs
      iii. Inadequate orientation of staff to Coordinated School Health Program policies
      iv. Inadequate facilities for physical activity and nutrition programs
      v. No articulation between K-12 programs and Institutions of Higher Education related to health education and physical education.

   ii. Health Education
      i. Many districts do not require a health education course graduation requirement
      ii. Many schools do not have a sequential, standards-based health education curriculum taught at all grade levels, particularly in relation to nutrition and physical activity topics
      iii. Lack of certified health education teachers
      iv. Need to promote culturally appropriate health topics including physical activity and nutrition
      v. Inadequate opportunities for students to practice skills and interact with family community
      vi. Need for an integrated interdisciplinary approach to health education

   iii. Physical Education
      i. Not all schools are meet the mandated time requirements for physical education (200 minutes per ten school days for grades 1-6; 400 minutes per ten school days for grades 7-12)
      ii. Many schools and districts do not provide a sequential, standards-based physical education curriculum
      iii. Most schools do not meet the recommended student/teacher ratio. The recommended ratio is “comparable” to other subject areas without counting paraeducators (aides) or volunteers as teachers in the ratio. Many physical education class sizes are in the 50s, and 60s; and some are even in the 70s, 80s and above.

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Schools Continued:

iv. Students are not active 50% of class time in most programs
v. Lack of certified physical education teachers at the elementary level
vi. Extensive substitutions for physical education at the secondary level
vii. Inadequate professional development of teachers of physical education at all levels
viii. Inadequate opportunities for extracurricular physical activities for all students

iv. Nutrition Services
  i. Not all school breakfast and meal programs adhere to national standards and statutory regulations
  ii. Many meal and a la carte choices do not include a variety of appealing low fat choices of fruits, vegetables, grains, and dairy products
  iii. Not all schools promote healthy cafeteria selections as well as pleasant, clean and safe cafeteria products
  iv. Not all schools certify food service staff and provide adequate continuing education

v. Health Services
  i. Some districts do not provide a recommended student to health service personnel ratio
  ii. Not all students with medical problems are identified and provided referrals
  iii. Some schools do not provide time for health service personnel to meet with other staff members for the purpose of sharing medical information relevant to physical activity and special dietary needs

vi. Counseling, Psychological, and Social Services
  i. Some districts do not provide a recommended student to counselor ratio
  ii. Not all students with problems are identified and referred to appropriate intervention sources
  iii. Some schools do not provide mental health staff with opportunities to participate in planning and policy development concerning physical activity and nutrition

vii. Health Promotion for Staff
  i. Some districts do not provide a budget for staff health promotion
  ii. Some districts do not provide physical activity/fitness nor nutrition education/weight management programs for staff

viii. Family and Community Involvement
  i. Some schools do not provide adequate community access to facilities outside of school hours

Appendix B-3

Schools Continued:

ii. Some schools do not educate families about physical activity and healthy eating nor provide adequate opportunities for student and family input into nutrition and physical activity programs

2. Suggested Recommendations to the Board of Supervisors

a. Develop a Coordinated School Health Program (CSHP) at each local education agency and adopt the use of the Centers for Disease Control and Prevention's School Health Index for Physical Activity and Healthy Eating as a tool for assessing the degree to which schools are meeting the nutrition and physical fitness standards for students. The actions to be taken to create a CSHP include the following:

1 School Policies & Environment

a. Publish comprehensive written District policies related to health, nutrition and physical education.
b. Create school-site committees that include students, parents, and community partners to oversee school health, nutrition and physical activity programs.
c. Provide access to adequate facilities for physical activities during and outside of school hours.
d. Orient all staff to District health policies.
e. Advocate for health education or physical education to be a college entrance requirement.
f. Offer physical activity before lunchtime.
g. Prohibit use of physical activity as punishment, and the use of food as a reward or punishment.
h. Prohibit sale and distribution of foods of low nutritional value on the school campus, such as, sodas and candy.
i. Identify fund raising efforts that support healthy eating to replace fundraisers such as candy sales.
j. Advocate for SB19 standards to be adhered to at all grade levels.
k. Ensure sufficient time to eat school meals.
l. Advocate for nutrition and physical fitness education to be a requirement in the curriculum for teacher training at the university level.
m. Ensure that all new schools constructed can accommodate: sufficient indoor and outdoor space for physical education; a cafeteria with sufficient space for on-site cooking as well as a salad bar; and an on-campus produce garden.
n. Create high school academies focusing on nutrition and physical activity.
o. Encourage colleges and universities to promote college credit opportunities for students who work with schools and communities in the areas of nutrition and physical education.

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Schools Continued:

2 Health Education
- a. Mandate health education taught by certified health education teachers.
- b. Provide students with sequential, standards-based health curriculum.
- c. Promote culturally appropriate examples of all health topics including physical activity and nutrition.
- d. Promote an integrated interdisciplinary approach to health education.
- e. Provide incentives to assure that nutrition education including how to cook healthy meals is addressed at every grade/school.
- f. Advocate for funding for health education on nutrition and physical activity, so these subjects are given the time in the curriculum given to other funded subjects such as drugs and HIV prevention.
- g. Promote health education mentoring programs focusing on nutrition and physical activity for high school student to work with elementary students.

3 Physical Education
- a. Provide physical education, which meets minimum time requirements and has students active at least 50% of the time.
- b. Utilize a sequential, standards-based curriculum taught by qualified teachers.
- c. Ensure a student/teacher ratio comparable to other subjects.
- d. Improve teacher professional development.
- e. Increase opportunities for extracurricular physical activities for all students.
- f. Develop joint use agreements with parks, fitness centers, and community centers to create more resources for physical activity in schools.

4 Health Services
- a. Collaborate with Health Services and other school staff to ensure that students' dietary and medical needs are accommodated.
- b. Provide time for key staff members to meet regularly regarding optimum nutrition and physical activities for students.
- c. Promote physical activity and healthy eating across the curriculum.

5 Nutrition Services
- a. Ensure that school breakfast and meal programs adhere to or exceed National standards and statutory regulations.
- b. Ensure that cafeteria meals, a la carte offerings, and venues outside the cafeteria include a variety of appealing and nutritional choices, including choices of fruits, vegetables, whole grain and low-fat dairy products.
- c. Increase the availability of quality salad bars in schools.
- d. Ensure that cafeteria and eating areas are clean, safe and pleasant.

Appendix B-3

Schools Continued:

e. Ensure that food service staff are certified and adequately trained.
f. Advocate for higher reimbursement for free and reduced cost school meals.
g. Ensure that all school sponsored programs, such as after school activities, athletics, and fund raisers adhere to nutrition standards.
h. Provide produce gardens in all schools.

6 Counseling, Psychological, and Social Services
a. Ensure that mental health staff have training in promotion of physical activity and healthy eating and in identification of eating disorders.
b. Ensure that mental health staff have opportunities to participate in planning and policy development concerning physical activity and nutrition.
c. Ensure that students with problems are referred to appropriate intervention sources and monitor to ensure participation.
d. Health Promotion for Staff
e. Provide physical activity/fitness, nutrition education and weight management programs for staff.
f. Ensure access to health screening for all employees.
g. Include staff health promotion as part of the District budget.
h. Family/Community Involvement
i. Educate families about physical activity and nutrition.
j. Involve parents, students, teachers, and community in planning school meals and health programs.
k. Allow community access to school facilities outside of school hours.
l. Promote community health programs and services.

Appendix B-4

Health Care Workgroup: Summary of Discussions to Date

1. Major issues and gaps in nutrition and physical activity within the context of Health Care:

a. Pregnancy and Infancy
   i. Intrauterine environment (i.e. lack of prenatal care, maternal factors increasing infant health risk)
   ii. Increased risk for nutritional deficits with low and high Infant birth weight and length
   iii. Abnormal weight gain in the first four months of life
   iv. Lack of support for breastfeeding initiation and sustaining duration
   v. Significant disparities with the African American and low income population
   vi. Late entry into prenatal care.

b. Early Childhood Through Adolescence
   i. Health care providers do not always track height and weight, provide nutritional or physical activity guidance, or diagnose children often enough as being overweight
   ii. Medical evaluation focuses on two extremes: underweight and overweight, or when a disease process has begun. There is not enough focus on prevention and staying healthy/fit
   iii. Fragmented health care system for foster care children
   iv. Lack of parenting education regarding child development and nutrition and physical activity needs.

c. Health Care Providers
   i. Lack of education among all health care providers
   ii. Lack of staff, services and physical activity and nutrition related resources
   iii. Lack of time to provided nutrition and physical activity interventions
   iv. Lack of funding reimbursement for nutrition and physical activity interventions
   v. Failure to address mental health issues
   vi. Health care worksites are not conducive to providers' health (i.e. snack foods in institutions, long hours, missing meals)

d. Data Needs
   i. Lack of collaborative data collection of heights and weights and risk factors associated with poor nutrition and sedentary behavior
   ii. Lack of centralized website for providers to access Los Angeles County data, research, and funding opportunities

Appendix B-4

Health Care Continued:

iii. Lack of evidenced based data on successful programs and strategies

e. Coordination of Effort
   i. Lack of a county wide coordinated effort to combat poor nutrition and sedentary behavior
   ii. Lack of media campaign messages promoting good health and physical fitness
   iii. Lack of an organized effort to reduce overweight and obesity among health care professionals.

2. Suggested Recommendations to the Board of Supervisors

a. Programs and Strategies
   i. Advocate that kids above >85% BMI receive a nutritional and fitness evaluation from their medical provider
   ii. Develop standardized, assessment, treatment and referral protocols in DHS facilities for overweight and obese individuals.
   iii. Establish a celebrity-based ongoing Task Force to draw attention to the prevention of childhood obesity and promotion of physical fitness
   iv. Establish a database to track BMI and make data available (potential data sites to include foster care, WIC and CHDP) Track BMI at the community level.
   v. Promote community and school linkages with hospitals that promote physical fitness and nutrition. Hospital with current community linkages include: Volunteer Hospital Association, California Hospital Medical Center and Huntington Memorial
   vi. Work with the private sector weight loss companies (e.g. weight watchers, Jenny Craig) to create countywide programs for children regardless of ability to pay
   vii. Develop a fitnessgram tool to be used in schools to track BMI at all grade levels and identify children at risk for overweight and obesity.
   viii. Utilize school nurses for BMI screening and mandate screening at all grade levels.
   ix. Increase community based resources like KidShape to support and offer services to children and youth.
   x. Implement support groups for parents and children in health care and school settings
   xi. Incorporate mental health services to address mental health issues associated with lack of physical activity, poor nutrition, overweight and obesity. (i.e. depression, eating disorders, self esteem, body image, abuse, etc.)
   xii. Play nutrition and physical activity videos in waiting rooms and in schools.
      - Make videos interesting
   xiii. Utilize celebrities to promote fitness through media campaigns and task force participation.

Appendix B-4

Health Care Continued:

xiv. Provide referrals to community programs based on BMI.
xv. Mandate a dietitian visit for all children >85% BMI

b. Public Awareness and Education Opportunities
   i. Advocate for Los Angeles County medical schools to include curriculum on how to counsel overweight and obese patients
   ii. Mandate nutrition and physical fitness education of Department of Health Services medical providers (health care providers: MDs, Nurses, Health Educators)
   iii. Educate health care providers through conferences, pamphlets and website access.
   iv. Mandate nutritional and physical fitness education to be a requirement of CME programs.
   v. Mandate nutrition, physical activity and Health education for child care and foster care families (tied to licensure)
   vi. Promote educational information for all pregnant women who have diabetes, develop gestational diabetes or are overweight/obese
   vii. Support public awareness campaigns
      - Messages need to be culturally appropriate
      - Campaigns need celebrity sponsorship
      - Nutrition and physical activity messages need to be about prevention, having fun and staying healthy
      - Create a logo for L.A.
      - Make fitness HIP
      - Use billboards with real people
      - Advertise physical activity and nutrition resources

c. Policy/Advocacy Opportunities
   i. Appoint a child and youth physical activity and nutrition legislative advisor to the Board of Supervisors
   ii. DHS to develop a comprehensive resource guide of nutrition, weight loss, and physical activity programs for medical providers (guide to be regularly updated)
   iii. Incorporate weight perception questions on the L.A. Health Survey for children
   iv. Incorporate physical fitness and nutrition into the core Department of Health Services Public Health goals
   v. Promote and support physical activity and nutrition legislation
      - Use BMI for measuring overweight and obesity
      - Taxation on soda and high sugar, high fat, low nutrient foods
      - Funding to support community based nutrition and physical activity programs (Develop a referral base)
      - Advocate for funding to support media campaigns
      - Advocate for the preservation of CHDP

Appendix B-4

Health Care Continued:

- Promote legislation to reimburse medical providers for overweight and obesity prevention services.
- Advocate for all entitlement programs cover obesity treatment and prevention
- Warning labels on high fat and high sugar foods

vi. Require restaurants to provide a healthy option (low sugar, low fat, low calorie) on all menus (Could link this requirement to the restaurant letter grade system or develop a grading system for healthfulness of food)
vii. Promote prevention opportunities, such as incentives for HMOs that provide health education and disease prevention classes.
viii. Develop a task force of hospital/clinic directors and administrators to develop and facilitate physical activity and nutrition opportunities.

d. Research Opportunities
   i. Develop pilot projects to determine the efficacy of screening for obesity and providing counseling and/or treatment to those who are obese
   ii. Promote research to determine effectiveness of programs targeting improving nutrition and increasing physical activity in County residents

e. Non-Health Care Related Recommendations
   i. Develop community programs that are bilingual/bicultural and meet the community's needs and desires.
      - Community Kitchens where healthy meals could be prepared for the neighborhood
      - Physical activity programs that are not viewed as exercise (e.g. dance programs)
      - Parent and child support groups
   ii. Optimize the use of County space, allowing community based programs to conduct services
   iii. Mandate daily physical activity and health education (including nutrition) for all grades.
   iv. Increase after-school programs
   v. Incorporate BMI calculation and nutrition/physical activity into general school curriculum (e.g. calculate BMI in math class, and write essays regarding nutrition and physical activity in English class)

Appendix B-5

Existing Resources as Identified by Ad Hoc Workgroups:

Local Programs

- Kid Shape
- Reach 2010
- WIC
- YMCA
- Boys and Girls Club
- 5 a Day - works with 9-11 year olds in schools; planning to expand.
- Boy Scouts
- Girl Scouts
- SPARKS
- CLASS Parks
- Beyond the Bell
- Farmers Markets
- CANFIT
- Project Lean (Leaders Encouraging Activity and Nutrition) – "Food on the Run" program in schools. Serves middle and high schools on an as-requested basis
- Pasadena Department of Public Health
- DHS Promotora Program
- DHS Ask the Dietitian
- DHS Stepping Up To Better Health
- Food on the Run
- Kids in Fitness
- PACE Program (Prescription for Physical Activity). After the patient fills out a short survey, s/he is given a prescription for physical activity.
- Power Play
- Dave Heber's program for teens
- Weight Watchers' points are a form of education.
- Walking programs
  - Take the stairs to strengthen your heart (there's data on promoting stairways)
  - Pedometers—some schools-based programs use them.
- Children's Hospital obesity treatment program
- "Changing the Scene" grants in Santa Monica and Hawthorne for policy development.
- CDC Index for Healthy Schools – simpler, easier to follow than "Changing the Scene."
- Nutrition Network – LAUSD only. Goal is to increase fruit and vegetable consumption. Can fund projects such as salad bars, can pay for gardening curriculum and training (not equipment anymore).

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Existing Resources Continued:

- Promotora project in SPA 4, using Hathaway – parent education by parents for parents.
- American Cancer Society works in schools
- A "best practice" is being implemented in the Seattle public school system; the media helped them produce a video for their project.

National Programs with possible local sites or funded programs

- National Center for Chronic Disease Prevention and Health Promotion
- American Association for Active Lifestyles and Fitness
- Presidents Council on Physical Fitness and Sports
- Shape Up America
- National Recreation and Park Association
- American Alliance for Health, Physical Education, Recreation and Dance
- Amateur Athletic Union
- National Association for Sport and Physical Education
- American Council on Exercise
- National Association for Health and Fitness
- Centers for Disease Control
- National Institute of Health

Appendix C

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5 A Day

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Appendix D

AMERICAN OBESITY ASSOCIATION FACT SHEET
(Source: American Obesity Association)[1]

Health Effects of Obesity - Persons with obesity are at risk of developing one or more serious medical conditions, which can cause poor health and premature death. Obesity is associated with more than 30 medical conditions, and scientific evidence has established a strong relationship with at least 15 of those conditions. Preliminary data also show the impact of obesity on various other conditions. Weight loss of about 10% of body weight, for persons with overweight or obesity, can improve some obesity-related medical conditions including diabetes and hypertension.

Obesity-Related Medical Conditions - The prevalence of various medical conditions increases with overweight and obesity for men and women as shown in Tables 1 and 2.

Table 1. Prevalence of Medical Conditions by Body Mass Index (BMI) for Men

Medical Condition	Body Mass Index			
	18.5 to 24.9	25 to 29.9	30 to 34.9	≥ 40
	Prevalence Ratio (%)			
Type 2 Diabetes	2.03	4.93	10.10	10.65
Coronary Heart Disease	8.84	9.60	16.01	13.97
High Blood Pressure	23.47	34.16	48.95	64.53
Osteoarthritis	2.59	4.55	4.66	10.04
Source: NHANES III, 1988 - 1994.				

Table 2. Prevalence of Medical Conditions by Body Mass Index (BMI) for Women

Medical Condition	Body Mass Index			
	18.5 to 24.9	25 to 29.9	30 to 34.9	≥ 40
	Prevalence Ratio (%)			
Type 2 Diabetes	2.38	7.12	7.24	19.89
Coronary Heart Disease	6.87	11.13	12.56	19.22
High Blood Pressure	23.26	38.77	47.95	63.16
Osteoarthritis	5.22	8.51	9.94	17.19
Source: NHANES III, 1988 - 1994.				

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Obesity Related Health Conditions

Arthritis

Osteoarthritis (OA)

- Obesity is associated with the development of OA of the hand, hip, back and especially the knee.
- At a Body Mass Index (BMI) of $\geq$ 25, the incidence of OA has been shown to steadily increase.
- Modest weight loss of 10 to 15 pounds is likely to relieve symptoms and delay disease progression of knee OA.

Rheumatoid Arthritis (RA)

- Obesity has been found related to RA in both men and women.

Birth Defects

- Maternal obesity (BMI $\geq$ 29) has been associated with an increased incidence of neural tube defects (NTD) in several studies, although variable results have been found in this area.
- Folate intake, which decreases the risk of NTD's, was found in one study to have a reduced effect with higher pre-pregnancy weight.

Cancers

Breast Cancer

- Postmenopausal women with obesity have a higher risk of developing breast cancer. In addition, weight gain after menopause may also increase breast cancer risk.
- Women who gain nearly 45 pounds or more after age 18 are twice as likely to develop breast cancer after menopause than those who remain weight stable.
- High BMI has been associated with a decreased risk of breast cancer before menopause. However, a recent study found an increased risk of the most lethal form of breast cancer, called inflammatory breast cancer (IBC), in women with BMI as low as 26.7 regardless of menopausal status.
- Premenopausal women diagnosed with breast cancer who are overweight appear to have a shorter life span than women with lower BMI.
- The risk of breast cancer in men is also increased by obesity.

Cancers of the Esophagus and Gastric Cardia

- Obesity is strongly associated with cancer of the esophagus and the risk becomes higher with increasing BMI.
- The risk for gastric cardia cancer rises moderately with increasing BMI.

Appendix D

Colorectal Cancer

- High BMI, high calorie intake, and low physical activity are independent risk factors of colorectal cancer.
- Larger waist size (abdominal obesity) is associated with colorectal cancer.

Endometrial Cancer (EC)

- Women with obesity have three to four times the risk of EC than women with lower BMI.
- Women with obesity and diabetes are reported to have a 3-fold increase in risk for EC above the risk of obesity alone.
- Body size is a risk factor for EC regardless of where fat is distributed in the body.

Renal Cell Cancer

- Consistent evidence has been found to associate obesity with renal cell cancer, especially in women.
- Excess weight was reported in one study to account for 21% of renal cell cancer cases.

Cardiovascular Disease (CVD)

- Obesity increases CVD risk due to its effect on blood lipid levels.
- Weight loss improves blood lipid levels by lowering triglycerides and LDL (“bad”) cholesterol and increasing HDL (“good”) cholesterol.
- Weight loss of 5% to 10% can reduce total blood cholesterol.
- The effects of obesity on cardiovascular health can begin in childhood, which increases the risk of developing CVD as an adult.
- Overweight and obesity increase the risk of illness and death associated with coronary heart disease.
- Obesity is a major risk factor for heart attack, and is now recognized as such by the American Heart Association.

Carpal Tunnel Syndrome (CTS)

- Obesity has been established as a risk factor for CTS.
- The odds of an obese patient having CTS were found in one study to be almost four times greater than that of a non-obese patient.
- Obesity was found in one study to be a stronger risk factor for CTS than workplace activity that requires repetitive and forceful hand use.
- Seventy percent of persons in a recent CTS study were overweight or obese.

Chronic Venous Insufficiency (CVI)

- Patients with CVI, an inadequate blood flow through the veins, tend to be older, male, and have obesity.

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Daytime Sleepiness

- People with obesity frequently complain of daytime sleepiness and fatigue, two probable causes of mass transportation accidents.
- Severe obesity has been associated with increased daytime sleepiness even in the absence of sleep apnea or other breathing disorders.

Deep Vein Thrombosis (DVT)

- Obesity increases the risk of DVT, a condition that disrupts the normal process of blood clotting.
- Patients with obesity have an increased risk of DVT after surgery.

Diabetes (Type 2)

- As many as 90% of individuals with type 2 diabetes are reported to be overweight or obese.
- Obesity has been found to be the largest environmental influence on the prevalence of diabetes in a population.
- Obesity complicates the management of type II diabetes by increasing insulin resistance and glucose intolerance, which makes drug treatment for type 2 diabetes less effective.
- A weight loss of as little as 5% can reduce high blood sugar.

End Stage Renal Disease (ESRD)

- Obesity may be a direct or indirect factor in the initiation or progression of renal disease, as suggested in preliminary data.

Gallbladder Disease

- Obesity is an established predictor of gallbladder disease.
- Obesity and rapid weight loss in obese persons are known risk factors for gallstones.
- Gallstones are common among overweight and obese persons. Gallstones appear in persons with obesity at a rate of 30% versus 10% in non-obese.

Gout

- Obesity contributes to the cause of gout -- the deposit of uric acid crystals in joints and tissue.
- Obesity is associated with increased production of uric acid and decreased elimination from the body.

Heat Disorders

- Obesity has been found to be a risk factor for heat injury and heat disorders.
- Poor heat tolerance is often associated with obesity.

Appendix D

Hypertension

- Over 75% of hypertension cases are reported to be directly attributed to obesity.
- Weight or BMI in association with age is the strongest indicator of blood pressure in humans.
- The association between obesity and high blood pressure has been observed in virtually all societies, ages, ethnic groups, and in both genders.
- The risk of developing hypertension is five to six times greater in obese adult Americans, age 20 to 45, compared to non-obese individuals of the same age.

Impaired Immune Response

- Obesity has been found to decrease the body's resistance to harmful organisms.
- A decrease in the activity of scavenger cells, that destroy bacteria and foreign organisms in the body, has been observed in patients with obesity.

Impaired Respiratory Function

- Obesity is associated with impairment in respiratory function.
- Obesity has been found to increase respiratory resistance, which in turn may cause breathlessness.
- Decreases in lung volume with increasing obesity have been reported.

Infections Following Wounds

- Obesity is associated with the increased incidence of wound infection.
- Burn patients with obesity are reported to develop pneumonia and wound infection with twice the frequency of non-obese.

Infertility

- Obesity increases the risk for several reproductive disorders, negatively affecting normal menstrual function and fertility.
- Weight loss of about 10% of initial weight is effective in improving menstrual regularity, ovulation, hormonal profiles and pregnancy rates.

Liver Disease

- Excess weight is reported to be an independent risk factor for the development of alcohol related liver diseases including cirrhosis and acute hepatitis.
- Obesity is the most common factor of nonalcoholic steatohepatitis, a major cause of progressive liver disease.

Low Back Pain

- Obesity may play a part in aggravating a simple low back problem, and contribute to a long-lasting or recurring condition.
- Women who are overweight or have a large waist size are reported to be particularly at risk for low back pain.

Appendix D

Obstetric and Gynecologic Complications

- Women with severe obesity have a menstrual disturbance rate three times higher than that of women with normal weight.
- High pre-pregnancy weight is associated with an increased risk during pregnancy of hypertension, gestational diabetes, urinary infection, Cesarean section and toxemia.
- Obesity is reportedly associated with the increased incidence of overdue births, induced labor and longer labors.
- Women with maternal obesity have more Cesarean deliveries and higher incidence of blood loss during delivery as well as infection and wound complication after surgery.
- Complications after childbirth associated with obesity include an increased risk of endometrial infection and inflammation, urinary tract infection and urinary incontinence.

Pain

- Bodily pain is a prevalent problem among persons with obesity.
- Greater disability, due to bodily pain, has been reported by persons with obesity compared to persons with other chronic medical conditions.
- Obesity is known to be associated with musculoskeletal or joint-related pain.
- Foot pain located at the heel, known as Sever's disease, is commonly associated with obesity.

Pancreatitis

- Obesity is a predictive factor of outcome in acute pancreatitis. Obese patients with acute pancreatitis are reported to develop significantly more complications, including respiratory failure, than non-obese.
- Patients with severe pancreatitis have been found to have a higher body-fat percentage and larger waist size than patients with mild pancreatitis.

Sleep Apnea

- Obesity, particularly upper body obesity, is the most significant risk factor for obstructive sleep apnea.
- There is a 12 to 30-fold higher incidence of obstructive sleep apnea among morbidly obese patients compared to the general population.
- Among patients with obstructive sleep apnea, at least 60% to 70% are obese.

Stroke

- Elevated BMI is reported to increase the risk of ischemic stroke independent of other risk factors including age and systolic blood pressure.
- Abdominal obesity appears to predict the risk of stroke in men.
- Obesity and weight gain are risk factors for ischemic and total stroke in women.

Appendix D

Surgical Complications

- Obesity is a risk factor for complications after a surgery.
- Surgical patients with obesity demonstrate a higher number and incidence of hospital acquired infections compared to normal weight patients.

Urinary Stress Incontinence

- Obesity is a well-documented risk factor for urinary stress incontinence, involuntary urine loss, as well as urge incontinence and urgency among women.
- Obesity is reported to be a strong risk factor for several urinary symptoms after pregnancy and delivery, continuing as much as 6 to 18 months after childbirth.

Other

- Several other obesity-related conditions have been reported by various researchers including: abdominal hernias, acanthosis nigricans, endocrine abnormalities, chronic hypoxia and hypercapnia, dermatological effects, depression, elephantitis, gastroesophageal reflux, heel spurs, hirsutism, lower extremity edema, mammegaly (causing considerable problems such as bra strap pain, skin damage, cervical pain, chronic odors and infections in the skin folds under the breasts, etc.), large anterior abdominal wall masses (abdominal paniculitis with frequent panniculitis, impeding walking, causing frequent infections, odors, clothing difficulties, low back pain), musculoskeletal disease, prostate cancer, pseudo tumor cerebri (or benign intracranial hypertension), and sliding hiatil hernia.

***Note**: Readers should note that researchers have not always used the same criteria to identify overweight and obesity. In this fact sheet, AOA has attempted to use the generally accepted definitions for overweight as a Body Mass Index (BMI) of 25 to 29.9 and obesity as a BMI of 30 or above. We have made an effort to identify studies which have used those specific definitions as well as other scientifically accepted measurements such as waist circumference and waist to hip ratio.*

Appendix E

COMMON ILLNESS ASSOCIATED WITH CHILDHOOD OBESITY
(Source: American Obesity Association)[2]

Asthma

- Prevalence of overweight is reported to be significantly higher in children and adolescents with moderate to severe asthma compared to a peer group.

Diabetes (Type 2)

- Type 2 diabetes in children and adolescents has increased dramatically in a short period. The parallel increase of obesity in children and adolescents is reported to be the most significant factor for the rise in diabetes.
- Type 2 diabetes accounted for 2% to 4% of all childhood diabetes before 1992, but skyrocketed to 16% by 1994.
- Obese children and adolescents are reported to be 12.6 times more likely than non-obese to have high fasting blood insulin levels, a risk factor for type 2 diabetes.
- Type 2 diabetes is predominant among African American and Hispanic youngsters, with a particularly high rate among those of Mexican descent.

Hypertension

- Persistently elevated blood pressure levels have been found to occur about 9 times more frequently among obese children and adolescents (ages 5 to 18) than in non-obese.
- Obese children and adolescents are reported to be 2.4 times more likely to have high diastolic blood pressure and 4.5 times more likely to have high systolic blood pressure than their non-obese peers.

Orthopedic Complications

- Among growing youth, bone and cartilage in the process of development are not strong enough to bear excess weight. As a result, a variety of orthopedic complications occur in children and adolescents with obesity. In young children, excess weight can lead to bowing and overgrowth of leg bones.
- Increased weight on the growth plate of the hip can cause pain and limit range of motion. Between 30% to 50% of children with this condition are overweight.

Appendix E

Psychosocial Effects & Stigma

- Overweight children are often taller than the non-overweight.
- White girls, who develop a negative body image, are at a greater risk for the subsequent development of eating disorders.
- Adolescent females who are overweight have reported experiences with stigmatization such as direct and intentional weight-related teasing, jokes and derogatory name calling, as well as less intentional, potentially hurtful comments by peers, family members, employers and strangers.
- Overweight children and adolescents report negative assumptions made about them by others, including being inactive or lazy, being strong and tougher than others, not having feelings, and being unclean.

Sleep Apnea

- Sleep apnea, the absence of breathing during sleep, occurs in about 7% of children with obesity. Deficits in logical thinking are common in children with obesity and sleep apnea.

Appendix F

Physical Activity Guidelines for Infants, Toddlers, Middle Childhood, and Adolescents
(Adapted from the National Association for Sport & Physical Education, 2002[3])

Infants:

Physical activity opportunities and nurturing of motor skill development during the first year of life establish the foundation of physical activity behaviors. In order for motor skills to mature, infants need to be exposed to stimulating environments that promote motor control and muscle development. Activities such as feeding, playing peek-a-boo, placing a toy just out of reach, and gently turning, rolling, bouncing and swaying are excellent ways to increase muscle strength and neural development.

Guideline 1. Infants should interact with parents and/or caregivers in daily physical activities that are dedicated to promoting the exploration of their environment.

Guideline 2. Infants should be placed in safe settings that facilitate physical activity and do not restrict movement for prolonged periods of time.

Guideline 3. Infants' physical activity should promote the development of movement skills.

Guideline 4. Infants should have an environment that meets or exceeds recommended safety standards for performing large muscle activities.

Guideline 5. Individuals responsible for the well-being of infants should be aware of the importance of physical activity and facilitate the child's movement skills.

Toddlers and Preschoolers:

During the toddler and preschool years (ages 1-4), children should be encouraged to practice movement in a variety of activities in order to develop advanced skills and patterns of motor coordination that can last a lifetime. Basic movement skills such as running, jumping, throwing, balancing, and kicking do not just appear because a child grows older, but emerge from an exposure to movement. Children of this age will generally play and explore, however, many only spend 10-20 percent of their time engaging in whole body physical activity (e.g. walking, running, climbing) and spend too much time participating in sedentary behaviors (watching television, video tapes, playing with toys that do not require movement)[4]. Running, jumping, climbing, throwing, catching, and playing simple games that incorporate those actions such a tag and hide-n-seek are appropriate activities for this age group. Organized activities such as tumbling, gymnastics and dancing are also appropriate, however, children under 6 years old do not have the motor skills, or mental and emotional capabilities to participate in organized sports[5].

Appendix F

Guideline 1. Toddlers should accumulate at least 30 minutes daily of structured physical activity and preschoolers at least 60 minutes.

Guideline 2. Toddlers and preschoolers should engage in at least 60 minutes and up to several hours per day of daily, unstructured physical activity and should not be sedentary for more than 60 minutes at a time except when sleeping.

Guideline 3. Toddlers should develop movement skills that are building blocks for more complex movement tasks; preschoolers should develop competence in movement skills that are building blocks for more complex movement tasks.

Guideline 4. Toddlers and preschoolers should have indoor and outdoor areas that meet or exceed recommended safety standards for performing large muscle activities.

Guideline 5. Individuals responsible for the wellbeing of toddlers and preschoolers should be aware of the importance of physical activity and facilitate the child's movement skills.

Middle Childhood:

Children from age 5 – 12 need to continue to be physically active in order to develop lifetime physical activity skills and require more physical activity than adults[6]. Physical activity for children clearly needs to be developmentally appropriate. Children have shorter attention spans and are concrete rather than abstract thinkers. Additionally, children typically engage in intermittent bouts of vigorous activity behavior and then need to rest. Thus children should be encouraged to be active in different types of activity throughout the day and accumulate at least 60 minutes or more of active behavior. Table 4 illustrates age appropriate middle childhood physical activity.

Guideline 1. Elementary school aged children should accumulate at least 30 to 60 minutes of age appropriate physical activity from a variety of physical activities on all, or most, days of the week.

Guideline 2. An accumulation of more than 60 minutes, and up to several hours per day of age and developmentally appropriate activity is encouraged for elementary school aged children.

Guideline 3. Some of the child's physical activity each day should be in periods lasting 10 to 15 minutes or more and include moderate to vigorous physical activity. This activity will typically be intermittent in nature involving alternating moderate to vigorous activity with brief periods of rest and recovery.

Appendix F

Guideline 4. Extended periods of inactivity are inappropriate for children.

Guideline 5. A variety of physical activities are recommended for elementary school children.

Table 4. Motor Skill Development During Middle Childhood[7]

Age Range	Motor Skills Being Developed	Appropriate Physical Activities
5–6 Years	Fundamental (e.g., running, galloping, jumping, hopping, skipping, throwing, catching, striking, kicking)	Activities that focus on having fun and developing motor skills rather than on competition Simple activities that require little instruction Repetitive activities that do not require complex motor and cognitive skills (e.g., running, swimming, tumbling, throwing and catching a ball)
7–9 Years	Fundamental Transitional (e.g., throwing for distance; throwing for accuracy)	Activities that focus on having fun and developing motor skills rather than on competition Activities with flexible rules Activities that require little instruction Activities that do not require complex motor and cognitive skills (e.g., entry-level baseball, soccer)
10–11 Years	Transitional Complex (e.g., playing basketball)	Activities that focus on having fun and developing motor skills rather than on competition Activities that require entry-level complex motor and cognitive skills Activities that continue to emphasize motor skill development but that begin to incorporate instruction on strategy and teamwork

Appendix F

Adolescents:

Participation in physical activity wanes as children get older and females are typically much less physically active than males. However, participation in physical activity still remains important. Regular physical activity in adolescents is necessary to improve strength, build lean muscle mass, and build stronger bones that will last into late adulthood.

Guideline 1. All adolescents should be physically active daily, or nearly every day, as part of play, games, sports, work, transportation, recreation, physical education, or planned exercise, in the family, school and community activities.

Guideline 2. Adolescents should engage in three or more sessions per week of activities that last 20 minutes or more at a time and require moderate to vigorous levels of exertion.

Appendix F-1

Calories Expended During Certain Activities:

ACTIVITY	*Calories expended in 30 minutes Male (175 lbs)*	*Calories expended in 30 minutes Female (135 lbs)*
Biking 12-13.9 mph (moderate effort)	334	258
Circuit Training	334	258
Stretching, hatha yoga	167	129
Dancing - general	188	145
Dancing - ballet, modern	251	193
House Cleaning - vigorous (mop, wash car)	188	145
House Cleaning - light (dusting, vacuuming)	104	81
Playing w/ kids moderate - walk/run	167	129
Gardening	209	161
Mowing lawn - Hand mower	251	193
Running - 6 mph	418	322
Jogging	292	225
Basketball - Game	334	258
Children's Games	209	161
Football	334	258
Frisbee	125	97
Horseback Riding	167	129
Skating	292	225
Soccer	292	225
Softball/Baseball	209	161
Tennis	292	225
Hiking	251	193
Walking - 4 mph, level surface	167	129
Walking - leisure	146	113
Canoeing/Rowing - moderate	292	225
Kayaking	209	161
Swimming laps freestyle - moderate	334	258

Source: ACSM Resource Manual for Guidelines for Exercise Testing and Prescription Third Edition

Appendix G-1

THE 2000 DIETARY GUIDELINES FOR AMERICANS[8]

AIM FOR FITNESS...

- Aim for a healthy weight.
- Be physically active each day.

Following these two guidelines are aimed at helping to keep individuals and family healthy and fit. Healthy eating and regular physical activity enable people of all ages to work productively, enjoy life, and feel their best. They also help children grow, develop, and do well in school.

BUILD A HEALTHY BASE...

- Let the Pyramid guide your food choices.
- Choose a variety of grains daily, especially whole grains.
- Choose a variety of fruits and vegetables daily.
- Keep food safe to eat.

Following these four guidelines builds a base for healthy eating. Using the Food Guide Pyramid helps to ensure that individuals get the nutrients their bodies need each day. Grains, fruits, and vegetables are the recommended foundation of daily meals. This forms a base for good nutrition, good health, and helps to reduce the risk of certain chronic diseases. Individuals are encouraged to be flexible and adventurous - trying new choices from the grains, fruits, and vegetables groups in place of some less nutritious or higher calorie foods usually eaten. Additionally, individuals need to always take steps to keep food safe to eat.

CHOOSE SENSIBLY...

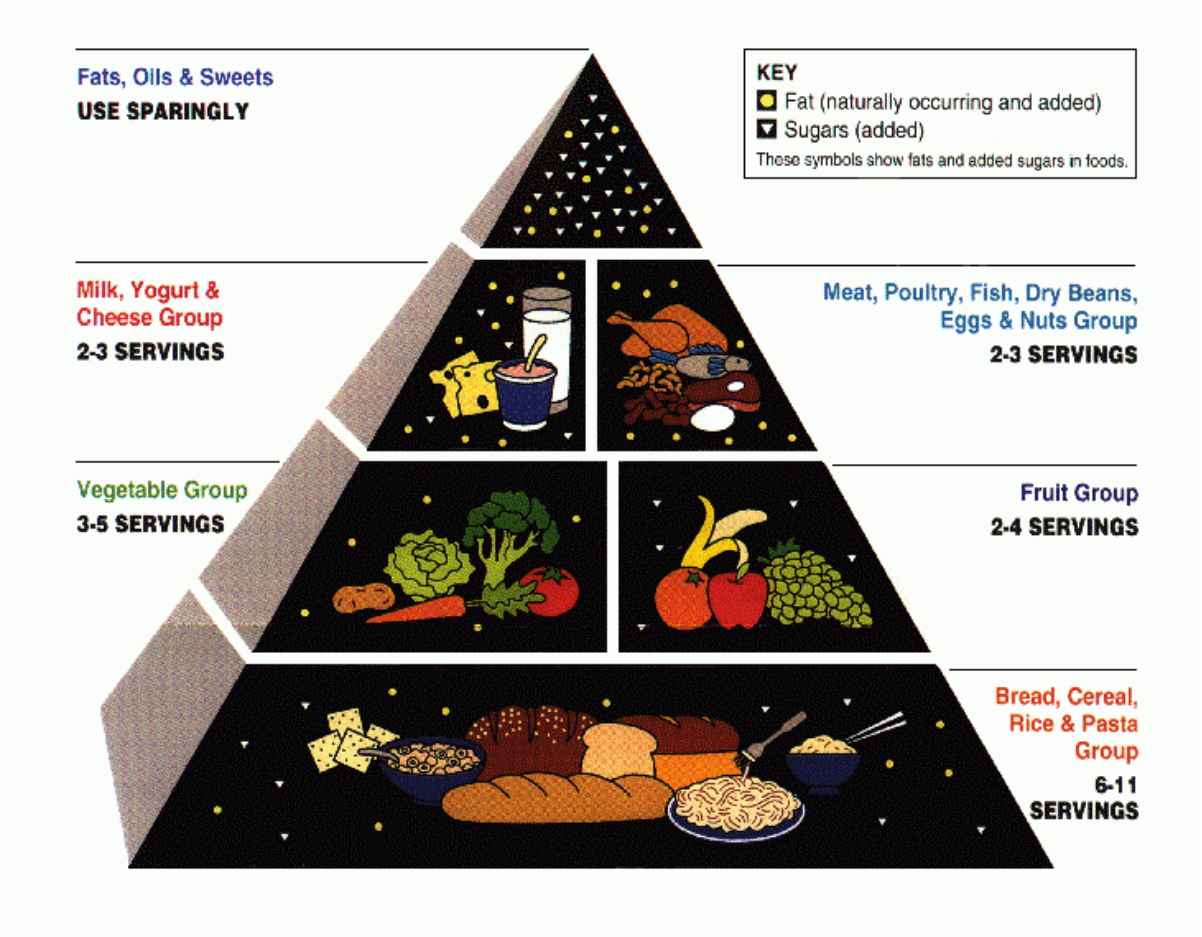
- Choose a diet that is low in saturated fat and cholesterol and moderate in total fat.
- Choose beverages and foods to moderate your intake of sugars.
- Choose and prepare foods with less salt.
- If you drink alcoholic beverages, do so in moderation

These four guidelines help people make sensible choices that promote health and reduce the risk of certain chronic diseases. All foods can be enjoyed as part of a healthy diet as long as individuals don't overdo it on fat (especially saturated fat), sugars, salt, and alcohol. People are encouraged to read labels to identify foods that are higher in saturated fats, sugars, and salt (sodium).

Appendix G-2

THE FOOD GUIDE PYRAMID[9]

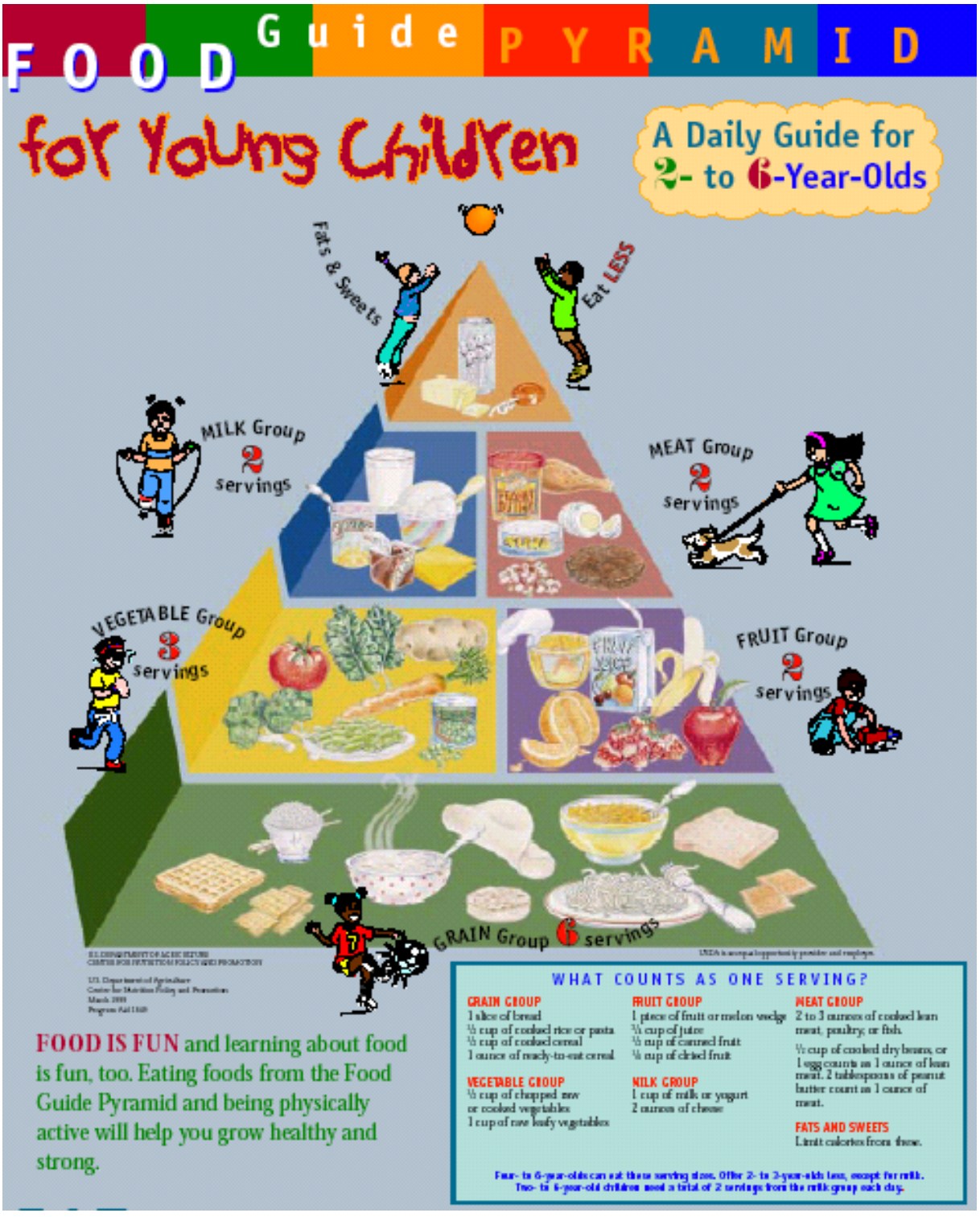
Number of servings per day



Source U.S. Department of Agriculture and U.S. Department of Health and Human Services

The Pyramid translates the recommended daily allowances and the Dietary Guidelines into food groups, listing the number of recommended servings to be consumed each day. Several culturally based food guide pyramids have been developed to assist people with placing traditional foods into the appropriate place in the pyramid (for culturally based food guide pyramids see, http://www.nal.usda.gov/fnic/Fpyr/pyramid.html). Additionally, the Food Guide Pyramid for Young Children (Appendix G-3) was developed to help improve the diets of children 2 to 6 years old. The guide was designed to be appealing to children, specify the recommended number food servings instead of providing a range, and promote the idea of physical activity through the pictures of the children playing around the pyramid.

Appendix G-3



Source: U.S. Department of Agriculture, Center for Nutrition Policy and Promotion.

Appendix G-4

Nutrition Facts Label

Macaroni and Cheese

Nutrition Facts

Serving Size 1 cup (228g)
Servings Per Container 2

Amount Per Serving	
Calories 250	Calories from Fat 110
	% Daily Value*
Total Fat 12g	**18%**
Saturated Fat 3g	**15%**
Cholesterol 30mg	**10%**
Sodium 470mg	**20%**
Total Carbohydrate 31g	**10%**
Dietary Fiber 0g	**0%**
Sugars 5g	
Protein 5g	
Vitamin A	4%
Vitamin C	2%
Calcium	20%
Iron	4%

*Percent Daily Values are based on a 2,000 calorie diet. Your Daily Values may be higher or lower depending on your calorie needs:

	Calories: 2,000	2,500
Total Fat	Less than 65g	80g
Sat Fat	Less than 20g	25g
Cholesterol	Less than 300mg	300mg
Sodium		2,400mg 2,400mg
Total Carbohydrate	300g	375g
Dietary Fiber	25g	30g

Source U.S. Department of Agriculture and U.S. Department of Health and Human Services

The nutrition facts label provides a basis for comparing nutrients and making informed choices when purchasing products. Key nutrients are displayed and the product ingredients in descending order. Most processed foods now include nutrition information. However, nutrition labels are not required for foods like coffee and tea (which contain no significant amounts of nutrients), certain ready-to-eat foods like unpackaged deli and bakery items, and restaurant food. Labels are also voluntary for many raw foods; however, grocer may supply this information for the fish, meat, poultry, and raw fruits and vegetables that are consumed most frequently.

Appendix H

NATIONAL AND STATE RECOMMENDATIONS

1. NATIONAL RECOMMENDATIONS

A. The Surgeon General's Report to Prevent and Decrease Overweight and Obesity[10]

I. The Nation must take an informed, sensitive approach to communicate with and educate the American people about health issues related to overweight and obesity. Everyone must work together to:
   a. Change the perception of overweight and obesity at all ages. The primary concern should be one of health and not appearance.
   b. Educate all expectant parents about the many benefits of breastfeeding.
   c. Educate health care providers and health profession students in the prevention and treatment of overweight and obesity across the lifespan.
   d. Provide culturally appropriate education in schools and communities about healthy eating habits and regular physical activity, based on the Dietary Guidelines for Americans, for people of all ages. Emphasize the consumer's role in making wise food and physical activity choices.

II. The Nation must take action to assist Americans in balancing healthful eating with regular physical activity. Individuals and groups across all settings must work in concert to:
   a. Ensure daily, quality physical education in all school grades. Such education can develop the knowledge, attitudes, skills, behaviors, and confidence needed to be physically active for life.
   b. Reduce time spent watching television and in other similar sedentary behaviors.
   c. Build physical activity into regular routines and playtime for children and their families. Ensure that adults get at least 30 minutes of moderate physical activity on most days of the week. Children should aim for at least 60 minutes.
   d. Create more opportunities for physical activity at worksites. Encourage all employers to make facilities and opportunities available for physical activity for all employees.
   e. Make community facilities available and accessible for physical activity for all people, including the elderly.
   f. Promote healthier food choices, including at least 5 servings of fruits and vegetables each day, and reasonable portion sizes at home, in schools, at worksites, and in communities.
   g. Ensure that schools provide healthful foods and beverages on school campuses and at school events by:
      ◊ Enforcing existing U.S. Department of Agriculture regulations that prohibit serving foods of minimal nutritional value during mealtimes in school food service areas, including in vending machines.
      ◊ Adopting policies specifying that all foods and beverages available at school contribute toward eating patterns that are consistent with the Dietary Guidelines for Americans.

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- ◊ Providing more food options that are low in fat, calories, and added sugars such as fruits, vegetables, whole grains, and low fat or nonfat dairy foods.
- ◊ Reducing access to foods high in fat, calories, and added sugars and to excessive portion sizes.

h. Create mechanisms for appropriate reimbursement for the prevention and treatment of overweight and obesity.

III. The Nation must invest in research that improves our understanding of the causes, prevention, and treatment of overweight and obesity. A concerted effort should be made to:
   a. Increase research on behavioral and environmental causes of overweight and obesity.
   b. Increase research and evaluation on prevention and treatment interventions for overweight and obesity and develop and disseminate best practice guidelines.
   c. Increase research on disparities in the prevalence of overweight and obesity among racial and ethnic, gender, socioeconomic, and age groups and use this research to identify effective and culturally appropriate interventions.

B. Healthy People 2010 Goals[11]

I. Improve accessibility of nutrition information, nutrition education, nutrition counseling and related services, and healthful foods in a variety of settings and for all population groups.
II. Focus on preventing chronic disease associated with diet and weight, beginning in youth.
III. Strengthen the link between nutrition and physical activity in health promotion.
IV. Maintain a strong national program for basic and applied nutrition research to provide a sound science base for dietary recommendations and effective interventions.
V. Maintain a strong national nutrition-monitoring program to provide accurate, reliable, timely, and comparable data to assess status and progress and to be responsive to unmet data needs and emerging issues.
VI. Strengthen State and community data systems to be responsive to the data users at these levels.
VII. Build and sustain broad-based initiatives and commitment to these objectives by public and private sector partners at the national, state, and local levels.

C. Task Force on Community Prevention Services[12]

I. Recommendations are based on a systematic review of community interventions shown to increase physical activity.
   a. Develop large-scale, highly intensive, community wide campaigns with sustained high visibility. Messages regarding physical activity behavior should be promoted through television, radio, newspaper columns and inserts, and trailers in movie theatres.

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b. Develop point of decision prompts to encourage stair use. Motivational signs should be place close to elevators and escalators encouraging use of nearby stairs for health benefits or weight loss.
c. Develop programs tailored to individuals' readiness for change or specific interest. Program design should include helping participants incorporate physical activity into their daily routines by teaching them behavioral skills specifically: 1) goal setting and self monitoring, 2) building social support, 3) behavioral reinforcement through self-reward and positive self-talk, 4) structures problem-solving, and 5) relapse prevention.
d. Develop social support interventions in community settings that focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change. Examples include exercise buddies, exercise contracts, and walking groups.
e. Modify school-based curricula and policies to increase amount of moderate or vigorous activity, increase the amount of time spent in physical education class, or increase the amount of time students are physically active in physical education class.
f. Create or enhance access to places for physical activity combined with informational outreach activities. Examples include attractive sidewalks, stairwells, walking or biking trails, and exercise facilities in communities or workplace.

D. **National Consensus Panel on School Nutrition**[13]
   I. Elementary Schools
      a. Eliminate sale of all foods sold outside the school meal program during the school day.
      b. Food and beverage items sold during morning and afternoon breaks must meet the standards described for secondary schools.
   II. Secondary Schools
      a. Allow the sale of water, low-fat/non-fat milk, and beverages that contain at least 50% fruit juice with no added sweeteners.
      b. Eliminate sale of soft drinks, sports drinks, punch, iced tea, and other drinks containing less that 50% real fruit juice.
      c. Eliminate the sale of beverages containing caffeine (except chocolate milk).
      d. Snacks, sweets and side dishes should not contain more than 30% calories from fat or 10% calories from saturated fat.
      e. Snacks, sweets and side dishes should not contain more than 35% added sugar by weight (except fresh, dried or canned fruits and vegetables)
      f. Limit portions sizes for snacks, sweets, side dishes and entrées.
         ◊ Portion size chart available
      g. Require the availability of quality fruits and vegetables at any place competitive foods are sold.

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2. RECOMMENDATIONS FOR THE STATE OF CALIFORNIA

A. The Public Health Institute[14]

I. Increase public awareness on the extent and causes of poor eating and exercise habits in adolescents and adults, the increasing rates of overweight, and the serious health, educational and economic implication for teens.
II. Communicate to parents, educators, health professionals and other adults who work with adolescents the environmental and policy strategies available to promote health eating and exercise and prevent overweight to help them incorporate appropriate preventive measures in their own settings.
III. Set reasonable expectations for slowing or reversing the rise in rates of obesity. Proceed with caution when implementing health promotion programs and policies to avoid stigmatizing at-risk and overweight adolescents, and put measures in place to prevent or eliminate discrimination.
IV. Promote leadership from the food and fitness industries, as well as other business that market to adolescents, to modify the design and marketing of products that have a negative impact on dietary quality, physical activity, body image and overall health attitudes and beliefs.
V. The federal government should coordinate a state nation response led by the Centers for Disease Control and Prevention. Similar to the early stage of other epidemics, an action-oriented nation grants program should be initiated.

B. California Center for Public Health Advocacy – California Working Families Policy Summit[15]

I. The State Legislature should establish a surcharge on the wholesale distribution of carbonated beverages. The revenue raised from the "soda surcharge" should be deposited into a "Child Health and Achievement Fund" to support programs that promote healthy eating and physical activity for children and adolescents, beginning with the following:
    a. State leadership activities:
        ◊ Develop major social marketing campaigns to promote healthy eating & physical activity.
        ◊ Fund expiring foundation grant-funded child nutrition initiatives such as 5-A-Day Power Play, Food on the Run, and SHAPE California.
        ◊ Continue to conduct and report the results of surveys and other surveillance efforts.
        ◊ Develop a Childhood Obesity Annual Report to the legislature, describing the status of childhood nutrition and physical activity needs, practices, and related health conditions.
        ◊ Provide programmatic and legal technical assistance to help schools and communities establish and implement local programs, policies, and regulations.

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b. Community Programs: Make incentive funds available to public and nonprofit agencies to:
   - ◊ Develop health-friendly community and transportation infrastructures, including parks, bike trails, safe walkways, and junk food-free zoning ordinances.
   - ◊ Gather input from residents to develop local nutrition and physical activity action plans.
   - ◊ Improve nutrition and physical activity standards in after-school and childcare programs.
   - ◊ Encourage affordable high quality grocery stores, farmers markets, and community gardens to be established in low-income neighborhoods.

II. The State Legislature and State School Board should work to ensure that the total school environment supports the developments of lifelong healthy eating and physical activity for all students.
   a. Physical Education
      - ◊ Ensure that all elementary school students participate in quality PE by establishing and adopting educational standards for PE as a separate area of study.
      - ◊ Require strict enforcement of the existing State PE mandates.
      - ◊ Require that questions about the importance of physical activity appear on the SAT 9 Test.
      - ◊ Require that schools provide parents written notification of their child's fitness test results.
      - ◊ Require school performance evaluations to include physical fitness test results.
      - ◊ Provide funding to schools to (a) decrease PE class size to equal other courses, (b) hire at least one credentialed PE teacher for every elementary school at least one day/week, and (c) provide professional development support for teachers in PE.
   b. Nutrition
      - ◊ Ensure that SB 19 (Escutia) is fully funded through 2007, implemented, and enforced.
      - ◊ Require that at least half of all food and beverages offered for sale on middle and high school campuses from vending machines, school stores, and as a la carte options meet the nutritional standards outlined in SB 19 (Escutia) for elementary school nutrition breaks.
      - ◊ Require that drinking water is available at multiple sites on school campuses.
      - ◊ Eliminate all commercialism of junk food from school campuses.
      - ◊ Require behavior-focused nutrition education to be integrated into the K-12 curriculum.

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- ◊ Require that questions about the importance of healthy eating appear on the SAT 9 Test.

c. School Infrastructure
- ◊ The State Legislature should utilize bond measures to raise funds to ensure safe and efficient operations of school cafeterias, PE facilities, and water fountains.

III. The State Legislature should work to restrict corporate advertising of junk food to young children, and ensure that consumers have the information they need to make healthy food choices
   a. Hold legislative hearings on the practice of junk food advertising targeting children.
   b. Within the State's jurisdiction (as determined by the Attorney General), prohibit local television stations from purchasing junk food ads for broadcast during children's programs.
   c. Within the State's jurisdiction (as determined by the Attorney General), limit junk promotions targeting young children.
   d. Require nutrition labeling on printed and posted menus and on all food packages in chain restaurants. Labels should not assume multiple servings per item.
   e. Require that 25% of menu options in fast food restaurants be "Heart-Healthy."

IV. The Governor, State Legislature and the California Congressional delegation should work to assert California's influence to advocate for changes in federal laws and regulations.
   a. Reduce or eliminate national television advertising of junk food to young children by:
      - ◊ Funding the University of California to publish a scientific report on the practice and health and economic consequences of marketing junk food to young children.
      - ◊ Holding Congressional hearings about corporate marketing practices.
      - ◊ Advocating for changes in Federal Trade Commission regulations.
   b. Support through funding and federal policy California's efforts to:
      - ◊ Establish competitive food standards in public schools.
      - ◊ Require nutrition labeling for restaurant foods.
      - ◊ Rebuild nutrition- and physical activity- related school and community infrastructures.
      - ◊ Increase reimbursement for healthy school meals.
      - ◊ Ensure that every child has access to affordable health care.

Appendix I

Healthy People 2010-Summary of Objectives for Nutrition and Overweight, Physical Activity, and Related Areas of Concern[16]

Nutrition and Overweight

Goal: Promote health and reduce chronic disease associated with diet and weight.

Number	Objective Short Title
Weight Status and Growth	
19-1	Healthy weight in adults
19-2	Obesity in adults
19-3	Overweight or obesity in children and adolescents
19-4	Growth retardation in children
Food and Nutrient Consumption	
19-5	Fruit intake
19-6	Vegetable intake
19-7	Grain product intake
19-8	Saturated fat intake
19-9	Total fat intake
19-10	Sodium intake
19-11	Calcium intake
Iron Deficiency and Anemia	
19-12	Iron deficiency in young children and in females of childbearing age
19-13	Anemia in low-income pregnant females
19-14	Iron deficiency in pregnant females
Schools, Worksites, and Nutrition Counseling	
19-15	Meals and snacks at school
19-16	Worksite promotion of nutrition education and weight management
19-17	Nutrition counseling for medical conditions
Food Security	
19-18	Food security

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Physical Activity

Goal: Improve health, fitness, and quality of life through daily physical activity.

Number	Objective Short Title
Physical Activity in Adults	
22-1	No leisure-time physical activity
22-2	Moderate physical activity
22-3	Vigorous physical activity
Muscular Strength/Endurance and Flexibility	
22-4	Muscular strength and endurance
22-5	Flexibility
Physical Activity in Children and Adolescents	
22-6	Moderate physical activity in adolescents
22-7	Vigorous physical activity in adolescents
22-8	Physical education requirement in schools
22-9	Daily physical education in schools
22-10	Physical activity in physical education class
22-11	Television viewing
Access	
22-12	School physical activity facilities
22-13	Worksite physical activity and fitness
22-14	Community walking
22-15	Community bicycling

Related Objective Areas of Concern

Access to Quality Health Services

1-3. Counseling about health behaviors

Arthritis, Osteoporosis, and Chronic Back Conditions

2-9. Cases of osteoporosis

Cancer

3-1. Overall cancer deaths
3-3. Breast cancer deaths
3-5. Colorectal cancer deaths
3-10. Provider counseling about cancer prevention

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Chronic Kidney Disease

4-3. Counseling for chronic kidney failure care

Diabetes

5-1. Diabetes education
5-2. New cases of diabetes
5-6. Diabetes-related deaths

Educational and Community-Based Programs

7-2. School health education
7-5. Worksite health promotion programs
7-6. Participation in employer-sponsored health promotion activities
7-10. Community health promotion programs
7-11. Culturally appropriate and linguistically competent community health promotion programs

Food Safety

10-4. Food allergy deaths
10-5. Consumer food safety practices

Health Communication

11-4. Quality of Internet health information sources

Heart Disease and Stroke

12-1. Coronary heart disease (CHD) deaths
12-7. Stroke deaths
12-9. High blood pressure
12-11. Action to help control blood pressure
12-13. Mean total blood cholesterol levels
12-14. High blood cholesterol levels

Maternal, Infant, and Child Health

16-10. Low birth weight and very low birth weight
16-12. Weight gain during pregnancy
16-15. Spina bifida and other neural tube defects
16-16. Optimum folic acid levels
16-17. Prenatal substance exposure
16-18. Fetal alcohol syndrome
16-19. Breastfeeding

Mental Health and Mental Disorders

18-5. Eating disorder relapses

Substance Abuse

26-12. Average annual alcohol consumption

Attachment J

Healthier US Initiative[17]

- Revitalize the President's Council on Physical Fitness and Sports. An important step in communicating the Administration's message on fitness and health is the revitalization of the President's Council on Physical Fitness and Sports. Football legend Lynn Swann will chair the council, and Olympic softball gold medalist and orthopedic surgeon Dr. Dot Richardson will serve as vice chair. The other members of the Council include professional athletes and trainers, U.S. Olympians, physicians and leading private sector experts. The Council will coordinate its activities with Federal, state, and private entities to serve communities across the country more effectively.

- Develop Agency-Wide Activities to Promote Personal Fitness. The President signed an Executive Order that directs certain Federal agencies to review all policies, programs, and regulations related to physical activity, nutrition, screenings, and making healthy choices. The agencies will propose revisions, modifications, or new actions to further improve the promotion of personal fitness, and forward the recommendations to the President within 90 days.

- Be Physically Active Every Day. Many chronic diseases can be prevented with modest exercise, in some cases as simple as walking for half an hour. For example, if just 10% of adults began walking regularly, America could save $5.6 billion in costs related to heart disease. There are countless opportunities for physical activity that do not need to be strenuous or very time-consuming to be beneficial. Administration actions to promote physical activity include:

  - Declaring a Fee-Free Weekend in America's National Parks and Federal Lands
  - Creating a HealthierUS.gov Web Site to Provide a Central Link to Government Fitness Resources
  - Promoting the Use of Public Lands and Water
  - Highlighting the Rivers, Trails, and Conservation Assistance Program

- Eat a Nutritious Diet. Americans should make simple adjustments to their diet and avoid excessive portions. Increasing fruit and vegetable consumption is a central part of a healthier diet, and good overall nutrition lowers the risk of getting heart disease, stroke, cancer, and osteoporosis. Administration actions to promote better nutrition include:

  - Enhancing the National 5 A Day for Better Health Program
  - Promoting Nutrition Curriculum and Education in Our Schools
  - Supporting the Eat Smart-Play Hard Campaign

- Get Preventive Screenings. Americans may be surprised to learn how a simple test like a cholesterol screen or a blood pressure check can reveal current health status and identify a need to adjust diet or behavior. Administration actions to promote preventive medicine include:

  - Creating the Healthy Communities Innovation Initiative
  - Raising Awareness of Diabetes Screening, Especially for Women
  - Strengthening and Improving Medicare

- Make Healthy Choices. Avoid tobacco and drugs and the abuse of alcohol and make smart and safe choices in your everyday life. Administration actions to promote healthy choices include:

  - Creating a CDC Tobacco Control Toolkit
  - Highlighting the Drug Free Communities Support Program
  - Promoting Bicycle Safety Initiatives

End Notes

[1] American Obesity Association. AOA fact sheets, health effects. Website: http://www.obesity.org/subs/fastfacts/Health_Effects.shtml.

[2] American Obesity Association. AOA fact sheets, obesity in youth. Website: http://www.obesity.org/subs/fastfacts/obesity_youth.shtml.

[3] National Association for Sport & Physical Education, Press Release: Physical Activity Guidelines for Infants and Toddlers, 2002, http://www.aahperd.org/naspe.

[4] Patrick K., B. Spear, K. Holt, and D. Sofka. eds. 2001. Bright Futures in Practice: Physical Activity. Arlington, VA: National Center for Education in Maternal and Child Health.

[5] Ibid.

[6] Pate R., C. Corbin, and B. Pangrazi. Physical Activity for Young People, President's Council on Physical Fitness and Sports Research Digest, Series 3, No.3, September, 1998.

[7] Patrick K., B. Spear, K. Holt, and D. Sofka. eds. 2001. Bright Futures in Practice: Physical Activity. Arlington, VA: National Center for Education in Maternal and Child Health.

[8] Dietary Guidelines Advisory Committee. 2000. Report of the Dietary Guidelines Advisory Committee on Dietary Guidelines for Americans, 2000. Website: http://www.ars.usda.gov/dgac/.

[9] Ibid.

[10] The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity 2001: Website: http://www.surgeongeneral.gov/sgoffice.htm Publications, Calls to Action.

[11] Healthy People 2010: http://www.health.gov/healthypeople/document/.

[12] Centers for Disease Control and Prevention. Increasing physical activity: a report on recommendations of the Task Force on Community Prevention Services. MMWR 2001;50(No.RR-18)

[13] California Center for Public Health Advocacy. National consensus panel on school nutrition: recommendations for competitive food standards in California schools. March 2002. Website: http://www.publichealthadvocacy.org/school_food_standards.

[14] Public Health Institute. 1998 California teen eating, exercise, and nutrition survey. September, 2000.

[15] California Center for Public Health Advocacy, California working families policy summit: nutrition and physical activity for children and adolescents. January 2002.

[16] Healthy People 2010: Website http://www.health.gov/healthypeople/document/

[17] Healthier US Initiative. Website: http://www.healthierus.gov.